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CHANGE OF PERSONAL INFORMATION FORM
 PLEASE PRINT

Personal Information		
First Name:	Last Name:	Last 4 Digits of SSN or Member ID:
Date of Birth: ____/____/____	Gender: Male <input type="checkbox"/> Female <input type="checkbox"/>	Current Marital Status: Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/>

Previous Contact Information (If updating mailing address)		
Street or PO Box:		Apartment or Suite #:
City:	State:	Zip Code:

Current Contact Information (Complete All Boxes)		
Street or PO Box:		Apartment or Suite #:
City:	State:	Zip Code:
Home Phone Number: ()	Mobile Phone Number: ()	Email Address:
Signature - Must be signed by Member or Legal Representative:		Date:

The information provided on this form is intended for UFCW & Employers Trust, LLC records. If applicable, the information will be used to provide you with health and/or pension related benefit information.

Please send the completed and signed form to:

UFCW & Employers Trust, LLC
Attention: Health and Welfare Services Dept.
P.O. Box 4100
Concord, CA 94524-4100

The information you provide UFCW & Employers Trust, LLC on this form will be shared with the benefit funds in which you participate and which are administered by UFCW & Employers Trust, LLC, in order to ensure communications for all Funds continue to reach you.